ABSTRACT

SOCIAL WORK

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THE IMPACT OF INDIVIDUALIZED COUNSELING WITH A WOMAN DIAGNOSED WITH MAJOR DEPRESSION

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The study examined different intervention approaches to treating Major Depression. The study was based on the premise that a combination of different approaches would be as or more effective than simply using one treatment approach.

The purpose of this study was to utilize individualized counseling as a treatment approach to decrease depressive symptoms in a woman diagnosed with Major Depression. One standardized measure was administered, the Generalized Contentment Scale. The intervention period lasted five months and consisted of individualized counseling provided by the client's therapist. The client answered the questionnaire after each individual session.

The results showed a minimal increase in general contentment within a five month intervention phase. The conclusion drawn from these findings suggests that factors other than individualized counseling should be considered as key elements in treating a patient with Major Depression. Those factors, both internal and external, include looking at the patient's social history and situation, family environment, cultural environment, physical health, social motivation and free will. This will help not only provide a more accurate diagnosis, but also a more effective intervention to cure targeted symptoms.

THE IMPACT OF INDIVIDUALIZED COUNSELING WITH A WOMAN DIAGNOSED WITH MAJOR DEPRESSION

A THESIS

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THE DEGREE OF MASTER OF SOCIAL WORK

BY

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CHAPTER ONE

INTRODUCTION

The epidemiological literature on mental illness indicates that a significant portion of the population is psychiatrically impaired. Exact rates vary according to the specific operational definition of psychological distress, but field studies since 1950, suggest that between 15 and 20 percent of the general population exhibit high symptomatology, with the proportions of mildly disturbed running as high as 80 percent.[1]

The origin of functional mental disorder is not clearly understood. Although recent methodological advances have shed some light on the possible genetic or biochemical causes of schizophrenia, sociopathic personality, and manic-depressive psychosis, these disorders comprise only a small part of the wide spectrum of mental disorders.[2] Uncertain causes makes for more difficult assessment and treatment planning for the various patients in mental health therapy.

In looking at depression as a mental illness, we find that the risk for clinical levels of depression is not evenly distributed within the general population.[3] Conservative estimates indicate that millions of people worldwide are depressed. In the United States, it has been calculated that in any six month period, 9.4 million people suffer from depression. It is also likely that at least one in every twenty Americans will have a major depressive disorder sometime in his or her lifetime. Many will experience depressions that do not reach clinical significance, but that do

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[1]Jerome K. Myers, Jacob L. Lindenthal, Max A. Pepper, and David R. Ostrander, "Life Events and Mental Status: A Longitudinal Study," Journal of Health and Social Behavior 13 (December 1972): 398.

[2]Gavin Andrews, Christopher Tennant, Daphne Hewson, and George Vaillant, "Life Event Stress, Social Support, Coping Style, and Risk of Psychological Impairment," The Journal of Nervous and Mental Disease 166 (May 1978): 307.

[3]Peter D. McLean and Sally Carr, "The Psychological Treatment of Unipolar Depression: Progress and Limitations," Canadian Journal of Behavioral Science 21 (1989): 463.

interfere with their functioning and cause untold suffering and pain.[4] The lifetime risk for experiencing a clinical level of any type of depression is approximately 12 percent for men and 20 percent for women.[5] Chance of occurrence is highest during the adult years. Remission rates for depressive disorders are relatively high, yet a substantial portion of those afflicted remain chronically depressed.[6]

There are many theories about the causes of depression. Clinicians, theorists and researchers usually take one of two sides in stating the cause of depression - primarily biological or primarily psychological. The biological causes are thought to stem from heredity and/or physiological disturbance. The latter focuses on the body's neurochemical, endocrine, and limbic systems, and the former on genetic transmission. Psychologcial causes are thought to include family origin (focusing on an individual's personality and development) and social influences (covering a broad range of social and cultural factors).[7]

Depression can be caused by a combination of factors. Genetic predisposition, developmental factors, psychological factors, and stress combine to create a final common pathway to depression. Each individual has a pattern of genetic, developmental, environmental, social, personality, and physiological factors that combine to permit or protect against depression at any point in time. Understanding and modifying the contributions of these factors is the goal of clinicians who treat depression.[8]

There is agreement among researchers and professionals, that risk for depression is elevated amongst women; young people; individuals who are separated,

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[4]Arthur Schwartz and Ruth M. Schwartz, Depression: Theories and Treatments (New York: Columbia University Press, 1993), 1.

[5]Idem, "The Psychological Treatment of Unipolar Depression: Progress and Limitations", 452.

[6]Leslie A. Robinson, Jeffrey S. Berman, and Robert A. Neimeyer, "Psychotherapy for the Treatment of Depression: A Comprehensive Review of Controlled Outcome Research<' Psychological Bulletin 108 (1990): 30.

[7]Schwartz and Schwartz, Depression: Theories and Treatment, 2.

[8]John H. Greist, M.D. and James W. Jefferson, M.D., Depression and Its Treatment, revised edition (Washington, DC: American Psychiatric Press, Inc., 1992), 8.

divorced, or in strained relationships; mothers who have three or more young children at home; the unemployed and disabled; and in those who have experienced prior episodes of clinical depression. Additionally, cognitive attributional style and dysfunctional attitudes, interpersonal functioning, childhood competence, and both social support/network and life stress, have been shown to place an individual at elevated risk for the development of clinical depression. These risks are not an only cause for the development of depression, but they do represent relative risks which appear to be cumulative within individuals in terms of increasing vulnerability.[9]

In addition to its different causes, depression has many diverse aspects. Depression can be a symptom (as when a person says, "I feel depressed"); a sign (when someone observes, "he looks depressed"); or a diagnosable disorder.[10] Usually, depression refers to a disturbance in mood. It has also been observed to be a reaction to certain substances, such as alcohol and other drugs. Depression may be a way of life - a way of coping. It can be a combination of any or all of these factors. In essence, depression manifests itself in different ways in different people, and sometimes in different ways in the same person at different times in that person's life.[11]

A wide variety of symptoms may indicate depression. More than 90 percent of depressed clients look sad, their mouths are often turned down at the corners, their eyes may appear red or swollen from crying and they may lack a sense of humor. They often speak of feeling "low", "down", and/or "blue".[12] Even if mood does not appear depressed, a person may lose interest or pleasure in most activities, this is sometimes called *adhedonia*. The depressed person often thinks negative thoughts about oneself, the present, and the future. This is usually coupled with complaints of poor concentration, poor memory, and difficulty in making decisions. Anxiety, a

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[9]Idem, "The Psychological Treatment of Unipolar Depression: Progress and Limitations", 452.

[10]John H. Greist, M.D., and James W. Jefferson, M.D., Depression and Its Treatment, rev. ed. (Washington, DC: American Psychiatric Press, Inc., 1992), 1.

[11]Schwartz and Schwartz, Depression: Theories and Treatment, 5.

[12]Ibid., 18.

sense that something unspecified but dreadful is going to happen is another symptom.[13] Other symptoms may include: loss of appetite, insomnia or hypersomnia, retardation of speech or movement, drop in libido, lowered self-esteem, feelings of helplessness and hopelessness, and thoughts of death and suicide.

The Diagnostic and Statistical Manual of Mental Disorders sets forth a system for providing professionals with precise, standardized criteria for diagnosing mental disorders. The manual gives specific information for each disorder, such as a description of the symptoms. The section covering the depressions is entitled "Mood Disorders". *Mood* is defined as a "prolonged emotion that colors the whole psychic life; it generally involves either depression or elation".[14] The following is what the manual considers to be the episode features of Major Depressive Episode:

> "The essential feature of a Major Depressive Episode is a period of at least two weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities ... The individual must also experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts ... The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning."[15]

The area of depression, perhaps more than other areas of mental illness, has attracted the attention of psychologists, with the result that there has been a variety of treatment strategies submitted to research. These treatment strategies have been theory driven, based on theoretical models oriented around a perceived deficit or characteristic of the depressed individual. This defect could include social skills deficit, irrational beliefs, or poor self-control. The Beck Depression Inventory is the

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[13]Idem, Depression and Treatment, 2.

[14]Diagnostic and Statistical Manual of Mental Disorders, 4th ed., American Psychiatric Association (Washington, DC: American Psychiatric Association, 1995).

[15]Ibid., 320.

common measure used in treatment outcome studies in which psychological treatment are featured.[16]

Although depression is common, even professionals are not united on defining what it is, and more important, on how to treat it. When depression is undiagnosed, or even when it is diagnosed but not treated properly, the patient may pay enormous psychological, physical, and economic costs. This is why an understanding of the many aspects of depression is a priority for all practitioners.[17]

Statement of the Problem

"The specific problem is the relationship of social to psychological impairment and its mediation. The generic problem is one of locating psychological processes and individual behavior within a societal framework".[18] Depression is a pervasive, important and intriguing problem, and although much is known about depression and its associated behaviors, the verdict is still out on what is the most effective treatment.[19] Depression is a prevalent clinical disorder with high economic and emotional costs. One study estimates the direct costs, including inpatient, outpatient, drugs, and other care costs are over 21 billion dollars a year. Indirect costs, including "total morbidity and mortality costs due to lost productivity" are over 14 billion dollars, or an estimated total of over 16 billion a year.[20]

"A review of the literature on depression reveals that there are difficulties posed by the heterogeneity of the concept."[21] This incongruity is manifested in terms of the definitions of duration, severity, age of onset, and etiology, all of which in turn

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[16]Idem, "The Psychological Treatment of Unipolar Depression: Progress and Limitations", 456.

[17]Schwartz and Schwartz, Depression: Theories and Treatment, 2.

[18]Ramsay Liem and Joan Liem, "Social Class and Mental Illness Reconsidered: The Role of Economic Stress and Social Support," Journal of Health and Social Behavior 19 (June 1978): 139.

[19]John B. Nezlek, Mark Imbrie, and Glenn D. Shean, "Depression and Everyday Social Interaction," Journal of Personality and Social Psychology 67 (1994): 1101.

[20]Schwartz and Schwartz, Depression: Theories and Treatments, 1.

[21]Hope R. Conte, Ph.D., and T. Byram Karasu, M.D., "A Review of Treatment Studies of Minor Depression: 1980-1991," American Journal of Psychotherapy XLVI (January 1992): 58.

have implications for response to treatment.[22] In Medical usage the word depression means several things. Depression as a disease with a pathogenesis and certain symptoms defined medically; depression as an illness, describing experience of the individual and reflecting the cultural definition of illness in general; and depression as a sickness describing societal recognition of the patient's state as a reason for obtaining sickness benefits and accepting lesser performance in societal roles.[23]

Social damage caused by depression has assumed enormous proportions. Depression is a major health problem.[24] There is a high probability that the incidence and prevalence of depression will grow in years to come. Our rapidly changing psychosocial environment often gives rise to situations of acute and/or chronic environmental stress, which may lead to depressive reactions. Phenomena such as the increase in morbidity from chronic diseases, wide-spread use of drugs, and the ever higher emphasis on the quality of life will bring an increase of depression and also higher rates of people seeking medical advice.[25]

Many people who suffer from depression are not properly diagnosed and treated. Whether they go directly to mental health practitioners, physicians, the clergy, or others for help with problems ranging from feelings of sadness, helplessness and despair, and even suicidal thoughts, to backache, sexual problems, fatigue, or vague aches and pains, they are not always diagnosed as depressed. In fact, no more than one-third of non-hospitalized people who have major depression receive mental health treatment, and from 50 to 70 percent of these people will return again and again to their physicians for medical treatments.[26] In spite of continued research efforts and

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[22]Ibid.
[23]Norman Sartorius, "Cross-Cultural Research on Depression," Psychopathology 19 (1986): 9.
[24]Ibid., 6.
[25]Ibid., 10.
[26]Schwartz and Schwartz, Depression: Theories and Treatments, 1-2.

successes in recent years, prevention and treatment of depressive disorders remain a major challenge for medicine and societies.[27]

Significance and Purpose of Study

One of the most difficult challenges for psychotherapy research has been to demonstrate convincingly the link between what occurs in the treatment hour and patient change.[28] Each therapeutic technique or action derives its meaning from the impact it has on the ongoing patient-therapist interaction. It is in this context that single-case research, which more naturally captures the context in which therapist and patient actions occur, can make a contribution to identifying causal relations.[29] Although the study of individual cases has long been a fundamental source of data for psychotherapy, single-case methodology has not been widely accepted as an effective strategy for intervention research.

For many reasons psychotherapy research has in recent years witnessed a renewed interest in the intensive study of the individual case. First, there has been a growing recognition of the limitations imposed by controlled clinical trials for informing us about how patients change through psychologically mediated interventions. There must be a close analysis of the therapist-patient interaction in order to be informed about how patients change through psychologically mediated intervention and to understand the processes that promote therapeutic change. The second reason involves the necessity to test clinical theoretical models. Although comparative treatment outcome studies can confirm the efficacy of the treatments under investigation, the probative value of such studies for the clinical constructs underlying these treatment models is indirect and limited. The third and final reason deals with the notation that psychotherapy research has had little influence on either

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[27]Idem, "Cross-Cultural Research on Depression", 10.

[28]Enrico E. Jones, Jess Ghannam, Joel T. Nigg, and Jennifer F.P. Dyer, "A Paradigm for Single-case Research: The Time Series Study of a Long-Term Psychotherapy for Depression," Journal of Consulting and Clinical Psychology 61 (1993): 381.

[29]Ibid.

theory building or clinical practice. "The primary means of clinical inquiry, teaching, and learning in psychotherapy has been and still remains the case study method, grounded in the tradition of naturalistic observation".[30]

Social workers have been major providers of mental health services since the early 1920's. "Social workers are trained to intervene when the individual and the environment do not mesh smoothly, causing discomfort or disruption for the individual or family, or demonstrating the need for social restructuring". Social workers' focus on the person-in-the-environment and the impact of this interaction on individuals and their psyches, was a unique contribution to the mental health movement.

The main purpose of this study is to further investigate the relative effectiveness of psychotherapy and pharmacotherapy used by social workers and other clinicians in treating depression. This writer believes that the symptoms of depression are best relieved by a combination of therapies which includes both psychotherapy and pharmacotherapy. This task will be accomplished by reviewing the literature on depression as a mental health disorder, and the various therapies used for treatment. Furthermore, baseline and interventions used with a client at a community mental health center will be reviewed.

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[30]Enrico E. Jones, "Introduction to Special Section: Single-Case Research in Psychotherapy," Journal of Consulting and Clinical Psychology 61 (1993): 371.

CHAPTER TWO

REVIEW OF THE LITERATURE

Related Research

The review of the literature consists of studies which discuss the efficacy of different treatments for depression.

It was not too long ago that depression was treated almost exclusively with medication. The 1970's brought about the development of new therapeutic approaches, each with a different etiological model for depression. The behavioral treatment approach treats depression as an outcome of a low rate of response-contingent positive reinforcement. The goal here is to increase reinforcement by encouraging participation in pleasant activities or by building the assertion skills necessary to elicit social rewards. Cognitive therapy, another treatment approach, came from Beck's view of depression as an affective response to negative beliefs. There are also a number of treatment techniques that have integrated elements from both cognitive and behavioral models.[1]

The results on comparisons between different types of therapy have been inconsistent. In 1989, the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research, conducted a large-scale study in order to compare the effectiveness of different types of treatment for depression. The trial which compared cognitive-behavioral therapy, interpersonal psychotherapy, and pharmacological therapy (imipramine), found little evidence of overall,

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[1]Leslie A. Robinson, Jeffrey S. Berman, and Robert A. Neimeyer, "Psychotherapy for the Treatment of Depression: A Comprehensive Review of Controlled Outcome Research", Psychological Bulletin 108 (1990): 30.

differential treatment efficacy among psychological and pharmacological treatments for major depression.[2]

There have been other studies that address the issue of the comparative efficacy of psychological and pharmacological therapies as a function of the initial severity of depression. Different studies such as Shaw (1977) found that cognitive therapy was more effective than behavioral treatment.[3] DiMascio (1979) found that there were differential effects during treatment according to the type of treatment received. Patients receiving amitriptyline showed a marked alleviation in sleep disturbance after one week, whereas patients receiving interpersonal psychotherapy (IPT) showed more rapid improvement on measures of dysphoria and apathy. Rush (1982) reported differential effects of cognitive therapy and imipramine on hopelessness and self-concept in thirty-five depressed outpatients. Cognitive therapy showed the greatest improvements in hopelessness and more generalized gains in self-concept.[4]

Contrary to the above findings, Thase, Simons, Cahalance, McGeary, and Harden (1991) found cognitive therapy to be equally effective by the end of treatment for depressed patients split into more and less severe sub-groups. Blackburn, Bishop, Glen, Whalley, and Christie (1981) found cognitive therapy to be more effective than pharmacological treatment in an outpatient population, but equivalent in efficacy to pharmacological treatment in a more severely depressed inpatient sample. Furthermore, in a review of psychological studies, Robinson, Berman, and Neimeye (1990) found no evidence of a systematic relationship between initial depression symptom severity and treatment

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[2]Peter McLean and Steven Taylor, "Severity of Unipolar Depression and Choice of Treatment," Behavior Research Therapy 30 (1992): 443.

[3]Idem, "Psychotherapy for the Treatment of Depression: A Comprehensive Review of Controlled Outcome Research", 30.

[4]John T. Watkins, William R. Leber, Stanley D. Imber, Joseph F. Collins, Irene Elkin, Paul A. Pilkonis, Stuart M. Sotsky, M. Tracie Shea, and David R. Glass, "Temporal Course of Change of Depression," Journal of Consulting and Clinical Psychology 61 (1993): 858-859.

outcome.[5] Few studies have obtained consistent results across all outcome measures or assessment points.

There are two primary hypotheses concerning why such inconsistencies exist. The first suggests that genuine differences in efficacy do exist, but have been obscured by variations across studies in factors such as treatment procedures, client selection, and therapist training. The second hypothesis states that there are no significant differences in the effects of the various therapy partly because there exists considerable overlap in their treatment methods. Furthermore, there is the issue of differences in researcher's allegiance, client populations, and therapy formats and how they contribute to inconsistent results across studies, few reviewers have systematically examined research relating these variables to outcome.[6] In essence, many researchers are finding through their studies, that the treatments reviewed in the National Institute of Mental Health Treatment of Depression Collaborative Research Program (cognitive-behavioral, interpersonal psychotherapy, imipramine), have all been effective in reducing depressive symptomatology to a significant degree.[7]

Taylor and McLean (1993), conducted a study using two different methods to define treatment outcome profiles (rationally-derived criteria and dynamic clustering), to evaluate four treatments of depression: behavior therapy, pharmacotherapy, psychodynamic psychotherapy and relaxation training (attention placebo). One hundred and ninety-six patients between the ages of twenty and sixty were recruited through newspaper announcements. The diagnosis of moderate to severe depression was made using a three-stage assessment consisting of (a) telephone screening to determine whether depressed mood had been present for at least one month; (b) a semi-structured clinical

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[5]Idem, "Severity of Unipolar Depression and Choice of Treatment," 444.
[6]Ibid., 31.
[7]Idem, "Temporal Course of Change of Depression", 858.

interview by a psychologist or psychiatrist to determine whether the subjects met certain criteria for depression; and (c) psychometric assessment.

All the treatments took place over a period of ten weekly sessions. Sessions were conducted by a licensed and experienced psychologist, psychiatrist, or physician. Psychodynamic psychotherapy consisted of using fundamental principles of short-term, insight-oriented, nondirective psychotherapy. Relaxation training consisted of progressive muscle relaxation. Behavior therapy used graduated practice and modeling techniques, with targets for intervention consisting of communication skills, behavioral productivity, social interaction, assertiveness, decision-making, problem-solving and self-control. Pharmacotherapy consisted of amitriptyline, starting at 75 milligrams a day and increasing over a ten day period to a fixed treatment dose of 150 milligrams a day.

Treatment effects were examined at post-treatment and three month follow-ups. Regardless of treatment, the majority of patients displayed either a recovery or non-remission outcome profile, with relatively few instances of remission followed by a recurrence of depression. These findings challenge the view that any of the treatments are associated with a strong tendency to relapse, at least over the three month follow-up period.[8]

Robinson, Berman, and Neimeyer found that investigations directly comparing two or more types of treatment provided a better assessment of relative efficacy. Outcomes for cognitive therapy did not differ from those of either a strictly behavioral approach or a cognitive-behavioral intervention. Cognitive-behavioral treatments did appear to produce more improvement than

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[8]Steven Taylor and Peter McLean, "Outcome profiles in the treatment of unipolar depression", Behavior Research Therapy 31 (1993): 326-327.

behavior methods used alone. General verbal therapy seemed less effective than all three of the alternative therapies with which it was compared.[9]

In a 1993 study conducted by Watkins et. al., two hundred and fifty moderately to severely depressed outpatients were randomly assigned to sixteen weeks of cognitive-behavior therapy, interpersonal psychotherapy, imipramine plus clinical management, or pill placebo plus clinical management. The primary interests in this study were to determine whether there might be differential changes among treatments at various points in time overall depressive symptomatology and on mode-specific measures.

It was hypothesized that patients treated with cognitive therapy would show earlier changes on dysfunctional attitudes; that patients seen in interpersonal therapy (IPT) would evidence more rapid changes on social adjustment; and that patients treated in the active pharmacotherapy condition would show the quickest alleviation of endogenous symptoms. The rationale for these target measures was based on the fact that (a) cognitive-behavioral therapy addresses distorted cognitions and underlying patterns of thinking or assumptions; (b) IPT strategies are used to manage several areas of interpersonal disturbance with the goal of improving the quality of social and interpersonal functioning; and (c) the tricyclic antidepressant imipramine has been demonstrated to alleviate neurovegatative and somatic symptoms of depression.

Overall, the findings from the repeated measures analyses and cohort analyses point out that there are hardly any significant early treatment differences. Both of the psychotherapies and imipramine-case management showed marked decreases in symptomatology over the course of treatment for the total sample and were very similar in their effects at the end of treatment.[10]

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[9]Idem, "Psychotherapy for the Treatment of Depression: A Comprehensive Review of Controlled Outcome Research", 35.

[10]Idem, "Temporal Course of Change of Depression", 858-864.

Psychotherapy

Psychotherapy is sometimes referred to as "talk" therapy. Clinicians and their patients typically engage in conversation about the patient's experiences, important relationships, and future goals, as well as feelings, thoughts, and behaviors they produce. Psychotherapy is usually most helpful for less severe depression, which forms the largest part of the depressive spectrum. Psychotherapy alone is less effective for more severe depression, but may be helpful in improving relationships, thinking patterns, or behaviors that may lead to depression.[11]

Clinical research has firmly established the efficacy of psychological intervention for depression. In studies comparing psychotherapy to no treatment, there was a positive effect of therapy that was both statistically reliable and substantial in magnitude. The research evidence demonstrates that the benefits of psychotherapy for depression are not short-lived.[12]

There are a few different specific types of psychotherapy. In supportive psychotherapy the patient is aided through learning how to utilize strengths, empathizing with their distress, explaining the course of depression, monitoring changes, and reassuring the patient that improvement will occur in time. With the patient's permission, support can also be provided to family members, friends, and other important people in the patient's life. When other treatments are ineffective, support provided by caring others, can sustain a person until depression resolves on its own with the passage of time.[13]

Dynamic psychotherapy seeks to understand unresolved, unconscious conflicts that may lead to depression. Depression is often described as anger

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[11]John H. Greist, M.D. and James W. Jefferson, M.D., Depression and Its Treatment, revised edition (Washington, DC: American Psychiatric Press, Inc., 1992), 43.

[12]Ibid., 40.

[13]John H. Greist, M.D. and James W. Jefferson, M.D., Depression and Its Treatment revised edition (Washington, DC: American Psychiatric Press, Inc., 1992): 44.

turned inward. Part of the therapeutic process involves helping the individual uncover, understand, and deal more appropriately with angry feelings, therefore leading to a recovery from depression. Techniques used in what is also known as psychoanalytic psychotherapy include interpretation of dreams, free association, and exploration of the past. Other psychodynamic therapists may use the same techniques, but focus more on present relationships and role functioning. Patient's are helped to understand the possible role of these factors in their depression and to find new ways of dealing with people and feelings.[14]

Interpersonal psychotherapy, also referred to as "talk" therapy, is probably the most studied, used and known type of psychotherapy for depression. Emphasis is placed on understanding and improving the relationship skills of the patient. Goals include reducing depressive symptoms, improving self-esteem, and helping the patient develop new strategies for improving social and interpersonal functioning.[15]

Interpersonal psychotherapy is most commonly thought of as a well-defined, short-term intervention directed specifically at the amelioration of depressive symptoms. The first study of its efficacy occurred in what was described as a "maintenance" trial which examined the effects of eight months of psychotherapy in comparison to continued pharmacotherapy in depressed women who had remitted following six to eight weeks of amitriptyline therapy.[16]

Interpersonal psychotherapy (IPT) is grounded in the work of the interpersonal and cultural schools. Its goals however, are somewhat different. Although the influence of the patient's early developmental experiences are acknowledged and considered, they are not essential for therapeutic purposes.

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[14]Ibid.

[15]Ibid., 45.

[16]Ellen Frank, "Interpersonal Psychotherapy as a Maintenance Treatment for Patients with Recurrent Depression," Psychotherapy 28 (1991): 259.

IPT strives to focus more on the current interpersonal relationships. The assumption being that interpersonal experiences in the patient's family of origin are reflected in current interpersonal attitudes and behaviors. The goal of IPT, which is based on the premise that depression, regardless of biological vulnerability or personality traits, occurs in a psychosocial and interpersonal context, is to improve functioning within interpersonal relationships.

Interpersonal psychotherapy aides the patient in developing more adaptive coping strategies for social and interpersonal problems associated with the onset of depressive symptoms. The goals are achieved by: (1) determining which of four common problems (grief, interpersonal disputes, role transitions, interpersonal deficits) are related to the patient's index episode and (2) working to resolve the difficulties the patient is experiencing in the most prominent problem area.[17]

A study was mentioned earlier that was conducted by Robinson, Berman, and Neimeyer (1990), in which they examined the overall effectiveness of psychotherapy as well as the relative effectiveness of different forms of treatment (cognitive, behavioral, cognitive-behavioral, and general verbal therapy). This analysis was based on a total of fifty-eight studies of psychotherapy for the treatment of depression. Results show post-treatment outcomes of depressed clients receiving psychotherapy were almost three-fourths of a standard deviation better than the outcomes of individuals not receiving therapy.[18]

Behavioral-Cognitive

Over the past two decades, behavioral-cognitive interventions have been demonstrated to be safe and effective treatments for depression. The National Institute of Mental Health Collaborative Research Program for the treatment of

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[17]Ibid., 259-260.

[18]Idem, "Psychotherapy for the Treatment of Depression: A Comprehensive Review of Controlled Outcome Research", 32-34.

depression has indicated that cognitive-behavioral interventions are as effective as anti-depressant medication.[19] Historically, the central theoretical construct of behavioral theories of depression has been that relatively low rates of positive experiences, especially those that are contingent upon an individual's behavior, constitute a critical antecedent for the occurrence of depression.[20]

The evidence indicating cognitive-behavioral therapy as most effective may occur because it provides patients with new skills in adaptive problem-solving and mood-management, offers patients new ways of thinking about himself, and suggests that a treatment response-then-recurrence profile is unlikely to be a common outcome pattern for behavioral-cognitive therapies.[21] Additionally, such therapies may significantly decrease the drop-out rate for treatment. In conjunction with pharmacotherapy, specific cognitive-behavioral techniques may be utilized to increase compliance with medical regimes and to decrease premature discontinuation of medication.[22]

There is further suggestive evidence that behavioral-cognitive therapies are associated with fewer relapses or recurrence than tricyclic pharmacotherapy. This may be so due to psychotherapies providing patients with skills in adaptive problem-solving and mood-management.[23] Furthermore, accumulating research attests to the efficacy of cognitive therapy in treating non-bipolar primary affective disorder.[24] The rationale of cognitive therapy is based on the theoretical assumption that the characteristic set of symptoms of depression stem from

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[19]Peter M. Lewinsohn, Harry M. Hoberman, and Gregory N. Clarke, "The Coping with Depression Course: Review and Future Direction", Canadian Journal of Behavior Science 21 (1989): 470.

[20]Ibid., 472.

[21]Steven Taylor and Peter McLean, "Outcome profiles in the treatment of unipolar depression", Behavior Research Therapy 31 (1993): 325.

[22]Idem, "The Coping with Depression: Review and Future Directions", 471.

[23]Steven Taylor and Peter McLean, "Outcome profiles in the treatment of unipolar depression" Behavior Research Therapy 31 (1993): 325.

[24]Anne D. Simmons, Ph.D.; Sol L. Garfield, Ph.D.; and George E. Murphy, MD, "The Process of Change in Cognitive Therapy and Pharmacotherapy for Depression" Archives of General Psychiatry 41 (1984): 45.

errors or deficits in thinking. Treatment is directed towards the modification and correction of both content and process of thinking. It is this cognitive change that is held responsible for the relief of affective and behavioral symptoms.[25]

Several writers have speculated as to the critical components of successful cognitive-behavioral treatments for depression. Zeiss, Lewinsohn and Munoz (1979), concluded that such treatments should begin with an elaborated, well-planned rationale that guides the patient to the belief that he can control his own behavior, and thereby, change his depression. They state that therapy should: (a) provide training in skills which the patient can use to feel more effective in handling his daily life; (b) emphasize the independent use of these skills by the patient outside of the therapy context, and must provide enough structure so that the attainment of independent skills is possible for the patient; and (c) encourage the patient's attribution that improvement in mood was caused by the patient's own increased skillfulness, not by the therapist's skillfulness.[26]

Similarly, in a review of behavioral treatments for depression, Hoberman and Lewinsohn (1985), noted the following six as essential strategies of cognitive-behavioral treatments for depression: (a) a functional analysis of depressive behavior which involves pinpointing specific person-environment interactions and events related to a particular patients' depression; (b) therapist and patient must redefine the presenting problems in terms that give the patient a sense of hope and control and which set the stage for changing behavior cognitions; (c) self-monitoring of both mood and daily activities allows the examination of specific circumstances and/or repeated patterns which influence fluctuations in an individual's mood; (d) teaching depressives to routinely set and plan for specific, realistic, and attainable goals and sub-goals; (e) remediation of specific

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[25]Ibid.

[26]Idem, "The Coping with Depression Course: Review and Future Directions", 473.

performance and skill deficits presented by depressed patients; and (f) making rewarding experiences contingent upon goal accomplishment, and gradually increasing the use of self-reinforcement in order to provide the patient with structure to increase mood-enhancing activities.[27]

Pharmacotherapy

"Anti-depressant medications are the cornerstone of treatment of major depression and often play a role in the treatment of less severe depressions".[28] Most patients can take antidepressant medication safely and with only minimal side effects to achieve a rapid recovery from depression. The antidepressants stand in a class by themselves and are not sedatives, "downers", "uppers", or "dope". They are not addicting.[29] The antidepressant drugs are generally divided into the tricyclic antidepressants, the MAO inhibitors, the atypical drugs and some newer second-generation antidepressants. The initial drugs were called tricyclics, directly referring to their chemical structure. The tricyclic drugs introduced in the late 1950's, are still the ones most often used for depression. They primarily block the reabsorption of the neurotransmitter norepinephrine and also effect receptor sensitivity. Currently nine tricyclic-type drugs are in use: imipramine (trade name Tofranil), amitriptyline (Elavil), doxepin (Sinequan), trimipramine (Surmontil), desipramine (Norpramin), mortriptyline (Pamelor), and protriptyline (Vivactil). The symptoms of approximately seventy percent of depressed clients who take tricyclic ease considerably within four to six weeks. The medication effects the levels of norepinephrine and serotonin, then the nerve cells alter the number of receptors on their surface, which changes mood.[30]

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[27]Ibid., 473-474.

[28]John H. Greist, M.D. and James W. Jefferson, M.D., Depression and Its Treatment, revised edition (Washington, DC: American Psychiatric Press, Inc., 1992), 51.

[29]Idem., Greist and Jefferson, 102.

[30]Arthur Schwartz and Ruth M. Schwartz, Depression: Theories and Treatmentts (New York: Columbia University Press, 1993), 65-66.

The other main class of medications for the treatment of depression are called monoamineoxidase inhibitors (MAOIs). They work by blocking the action of the MAO enzyme, so that less norepinephrine is metabolized and more is available to cross the synaptic cleft. The most frequently used MAO inhibitors are isocarboxazid (trade name Marplan), phenelzine (Nardil), and tranylcypromine (Parnate). MAO inhibitors are sometimes used as second or third choice in treating major depression due to their many negative side effects.[31]

Lithium is another medication used primarily in the treatment of mania and depression when those two disorders occur together or in sequence, or in cases where depression is the only problem.[32] Lithium tends to stabilize mood at a more normal level. In this sense, lithium is beneficial in ending manic and depressive episodes as well as preventing them for reoccurring.[33] A recent, also atypical drug is bupropion (Wellbutrin), which inhibits the reabsorption of both dopamine and norepinephrine. Pharmacologically it is similar to such stimulants as the amphetamines (Ritalin).[34]

Although antidepressants are considered standard treatment, many depressed patients are initially treated by family physicians with benzodiazepines. Alprazolam is an antianxiety drug or minor tranquilizer of the benzodiazepine family. The dose of alprazolam, or Xanax, required for antidepressant benefit may be higher than the effective antianxiety dose.[35] Rickels et al (1987), conducted a six week double-blind study in which alprazolam was compared to an equipotent dose of diazepam, using imipramine and a placebo as a statistical yardstick. Two-hundred and forty-one patients

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[31]Ibid, 67.
[32]Idem., Greist and Jefferson, 52.
[33]Ibid, 69.
[34]Idem., Schwartz and Schwartz, 67.
[35]Idem., Greist and Jefferson, 72.

diagnosed with major depressive disorder participated. Fifty-eight patients received alprazolam, sixty-eight imipramine, fifty-nine diazepam, and sixty-one a placebo. Medication was randomized and prepared in identical looking capsules containing either 0.5 mg of alprazolam, 5 mg of diazepam, 25 mg of imipramine hydrochloride, or placebo. Treatment was initiated with one capsule three times a day given for three days, followed by four capsules a day during the remaining four days of the first week. After one week of therapy, medication was increased to six capsules a day unless side effects prevented such an increase. If no measurable improvement was noted after two weeks of therapy, and if no disturbing side effects were present, medication was increased to nine capsules per day. After one week of treatment, both benzodiazepines produced slightly more improvement then imipramine and placebo. This study supports the antidepressive effects of alprazolam observed in other outpatient studies, and provides additional information that the triazolo benzodiazepine alprazolam exerts significantly more antidepressive effects than placebo. Depressed outpatients suffering from moderately severe depression thus appear to represent a population responsive to alprazolam.[36]

Five double-blind, placebo-controlled studies with adinazolam mesylate (DERACYN tablets, the Upjohn company), were conducted in patients with DSM-III Major Depression. Adinazolam is a triazolobenzodiazepine that appears to be an effective antidepressant. Patients who fulfilled the entrance criteria were randomized to receive either adinazolam or placebo tablets for six weeks.[37]

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[36]Karl Rickels, M.D.; Hack R. Chung, M.D.; Irma B. Csanalosi, M.D.; Aaron M. Hurowitz, D.O.; Jerry London, D.O.; Kenneth Wiseman, D.O.; Myron Kaplan, D.O.; and Jay D. Amsterdam, M.D., "Alprazolam, Diazepam, Imipramine, and Placebo in Outpatients with Major Depression", Archives of General Psychiatry 44 (October 1987): 862-866.

[37]John P. Feighner, M.D., "A Review of Controlled Studies of Adinazolam Mesylate in Patients with Major Depressive Disorder", Psychopharmacology Bulletin 22 (1986): 186-190.

A total of 172 patients were treated with adinazolam and 171 patients were given a placebo. One hundred and sixty-four adinazolam treated patients and 158 placebo treated patients completed more than five days of study medication and were considered evaluable. Adinazolam was superior to placebo in almost all measurements. Id had a rapid onset of action, providing a significant antidepressant effect after two to seven days in most participants. Adinazolam alleviated the core symptoms of depression in these studies, and it appeared useful in severe or moderate Major Depression, in chronic or relatively acute depression, and in drug-resistant depression.[38]

Combinations of various cyclic antidepressants or a few cyclic and MAOI antidepressants are sometimes effective when single drugs have failed to help a patient. Adding lithium to a cyclic or MAOI antidepressant is often effective in over-coming an otherwise resistant depression. Other medications shown to have some beneficial additive effect are thyroid hormone, buspirone, and occasionally stimulants such as dextroamphetamine or methylphenidate.[39]

Theoretical Framework

Cognitive processes such as pessimistic thinking, gloomy thoughts, and a negative view of the future have long been observed as part of depression. Aaron Beck has emphasized that these cognitive processes are not a by-product of depression, but are "integrally involved in the development and the continuance of depression."[40] This study is guided by Beck's treatment approach which he labeled cognitive therapy, but has now evolved into a cognitive-behavioral approach.

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[38]Ibid.
[39]Idem, Greist and Jefferson, 69.
[40]Idem, Schwart and Schwartz, 243.

Beck has theorized that depressions are closely linked to the way a person thinks - to his cognitions or patterns of thought. Beck sees depression as resulting primarily from the negative cognitions of the patient. Based on these negative cognitions, the depressed person will interpret his past and present experiences as failures, and also anticipates his future experiences to be failures. He develops a low self-esteem based on viewing himself as inadequate or flawed when compared to others.[41]

By using specific educational, cognitive, and behavioral techniques, cognitive-behaviorists help their patients by focusing on their negative cognitions about themselves, the world, and the future. Usually, behaviors are changed first before focused work begins on cognitions, which in turn, precedes improvements in mood.[42] Clients are not persuaded to change their beliefs by efforts of debate and persuasion, rather they are encouraged to gather information about themselves through unbiased experiences which allow them to disconfirm their false beliefs.[43] In essence "clients are trained to use the outcomes of their behaviors to test the accuracy of their beliefs".[44]

The cognitive triad, schema, and automatic thoughts are three main concepts Beck developed while exploring the role of cognitions in depression. The cognitive triad refers to "a typical disturbance of thought patterns common to many depressives".[45] First, based upon his negative life experiences, the patient sees the world as a hostile, non-giving, aversive place. Next, the patient has a very negative view of himself, which could be based on his dismal life experiences. These perceived defects and shortcomings contribute to his feelings

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[41]Ibid, 244.

[42]Idem., Griest and Jefferson, 46.

[43]Robert C. Carson and James N. Butcher, Abnormal Psychology and Modern Life, 9 ed. (New York: HarperCollins Publishers, Inc., 1992), 648.

[44]Idem., Schwartz and Schwartz, 472.

[45]Ibid, 244.

of helplessness and hopelessness. The triad is completed with the patient experiencing a very negative view of the future, which may indicate future suicidal ideations, plans, and/or attempts.[46] Cognitive restructuring is useful in assisting patients to gain awareness of such dysfunctional and self-defeating thoughts which impair their social and personal functioning. These thoughts should be replaced with beliefs and behaviors that are aligned with reality and lead to enhanced functioning.[47]

Schema was used by Beck to help explain the persistence of negative and pessimistic thoughts. This concept is based upon Beck's belief that each person responds to and interprets stimuli from the environment in a unique and personal way. A pattern of summarizing and making sense of whatever is happening is formed based upon the patient's previous life experiences. These patterns, in turn, provide a framework or a schema for interpreting and reacting to situations. The schema is used as a screen to filter elements of reality the person is facing and to help him formulate and categorize his experiences.[48]

The final concept which Beck contributed to the cognitive-behavioral approach to treating depression is automatic thoughts. Beck found that while working with patients in individual therapy, they would often be free-associating and a stream of other thoughts would occur at the same time. The patient usually only reported one thought to the therapist because he was not fully conscious of the other thoughts or was reluctant to report them. Beck identified these as negative automatic thoughts. For example, a female patient could be discussing some of her conflicts about sex, but also be showing signs of anxiety. Beck questions her and she reports the following thoughts as intruding upon her

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[46]Ibid.

[47]Den H. Hepworht and JoAnn Larsen, Direct Social Work Practice: Theory and Skills, 4 ed. (California: Brooks/Cole Publishing Co., 1993), 423.

[48]Idem., Schwartz and Schwartz, Depression: Theories and Treatment, 245.

free association: "I am not expressing myself clearly . . . He is bored with me". Beck concluded that her central conflict was about self-esteem, not sex.[49]

Automatic thoughts may contribute to the formation and maintenance of the three elements of the cognitive triad. Examining these thoughts can help the therapist to understand emotional conditions such as depression. This examination has several phases. The first is to elicit the thoughts and make the patient aware of the parallel stream of thoughts. Second, treat the thoughts as a hypothesis and examine whether they are valid. Finally, identify and examine any underlying maladaptive assumptions. This final stage can be helpful in changing cognitions, which eventually changes behavior. According to Beck's theory, this will ease and eventually overcome the depression.[50]

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[49]Ibid.

[50]Idem., 246.

CHAPTER THREE

METHODOLOGY

Setting

This study was conducted at South Fulton County Mental Health Center, a public agency under the Georgia state Department of Human Services. The center provides individual and group counseling, psychiatric assessments, medications, and community referrals for children, adolescents, and adults with a wide range of mental disorders.

South Fulton has a staff of six adult clinicians, three child and adolescent clinicians, four part-time psychiatrists, two full-time psychiatrists, one full-time nurse, three adult day treatment program clinicians, five clerical and support staff, one medical director, and one center director.

The center is located at 1636 Connally Drive in East Point, Georgia, behind the W.T. Brooks Grady satellite medical clinic.

Background of Study

The subject of this study is Ms. G.G. a thirty-four year old African American female with an undergraduate degree in Communications. Ms. G.G. has been diagnosed with Major Depression. She first entered treatment voluntarily in 1993, at Georgia Mental Health Institute due to complaints of suicidal thoughts with intent. The client reported being depressed, tearful, fearful of losing control, and suicidal. G.G. has a past history of sexual abuse and chronic dysthymia. She also has a history of outpatient counseling with a private psychiatrist in new York, but no inpatient hospitalization for psychiatric problems or substance abuse. Upon discharge from GMHI, the client was referred to North Dekalb Mental Health Center and later to South Fulton Mental Health Center, with the recommendation to participate in treatment and take medication as deemed necessary.

G.G. is somewhat overweight, pleasant and appears intelligent. She has no history of substance abuse, even though her step-father was an alcoholic. G.G. is the youngest of three children. She has an older brother who lives in New York and an older sister in Georgia. The client states that her relationship with them was not good as a child because they did not pay her any attention. However, now their relationship is better. Client currently lives with her mother and sister. Her father died when she was an infant. G.G.'s childhood memories include being touched inappropriately and fondled by her two older male cousins when she eight or nine years old.

With good intentions, G.G. often mentions going back to school to earn a graduate degree or about getting a job in journalism. She feels though, that her condition and need to take medications are a hindrance. She has a hard time motivating herself or even being motivated by others to participate in any kind of activity. Her biggest accomplishment has been being the recording secretary for community meetings in the day treatment program. G.G. has a high potential functioning level, but does not rise to meet that occasion which frustrates her family and clinical staff that work with her.

One way to characterize G.G.'s illness is by using the term "hopelessness" as hypothesized by researchers Abramson, Metalsky and Alloy. Hopelessness is a theory created based upon the 1978 theory of helplessness. This type of depression can be characterized by a number of symptoms: lack of energy, apathy, psychomotor retardation, sleep disturbance, difficulty in concentrating, low self-esteem, dependency, and suicidal ideations. The main premise of this theory is that the client has an expectation that "highly desired outcomes will not occur or that highly aversive outcomes will occur coupled with an expectation that no response in one's repertoire will change the likelihood of occurrence of these outcomes."[1] The hopelessness theory

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[1]Lyn Y. Abramson, Gerald I. Metalsky, and Lauren B. Alloy, "Hopelessness Depression: A Theory-Based Subtype of Depression," Psychological Review 96 (1989): 359.

specifies a sequence of events which begins with the perceived occurrence of negative life events (or having no positive events occur) and culminates in the above described cause of the client's depressive symptoms. Hopelessness as a theoretical concept, explains how in G.G.'s situation, hope is lost, leaving behind a person who feels inferior and gives in to learned helplessness.

Treatment Hypotheses

The major focus of this study was that the client's participation in individualized counseling would increase the client's level of motivation. It was further hypothesized that her participation in the counseling sessions would lead to a decrease in her depressive symptoms (tearfulness, suicidal ideations, fearfulness).

Outcome Measures

"One of the encouraging innovations in measurement for single-system evaluation in clinical practice has been the development of a set of standardized scales by Hudson and his co-workers - the WALMYR Assessment Scales. These questionnaires were designed specifically for single-system evaluation to monitor and evaluate a client's problem through periodic administration of the same questionnaire to the client."[2]

The outcome measure used to assess the target behavior was the Index of Generalized Contentment Scale (GCS). The Index of Generalized Contentment is a 25-item questionnaire designed to measure the degree of magnitude of problem the client has with life and her surroundings. It is a self-administered questionnaire. The scale has a reliability of .90 or better and has good content, concurrent, factorial, discriminant and construct validity.[3]

The higher the score the greater the magnitude of the problem. The scale has a clinical cutting score, which indicates the absence or the presence of the problem, of 30. The idea here is that people who score over 30 generally have been found to have

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[2]Martin Bloom, Joel Fischer, and John G. Orme, Evaluating Practice: Guidelines for the Accountable Professional, second edition (Boston: Allyn and Bacon, 1995), 194.

[3]Ibid., 195.

problems in the area being measures, while people who score below 30 have been found not to have such problems.[4]

Intervention Strategies

Review of progress notes and consultation with G.G.'s therapist (R.K.) revealed that most individual counseling sessions combined different types of individual counseling techniques, with a strong emphasis on cognitive restructuring. The therapist helped the client gain awareness of her dysfunctional and self-defeating thoughts and misconceptions that were impairing her personal functioning. These thoughts and misconceptions were replaced with beliefs and behaviors that were more aligned with reality and led to enhanced functioning.

The first few sessions involved the therapist assisting the client in accepting her current self-statements, assumptions, and beliefs as contributing to her emotional reactions to life's events. This process also entailed boosting the client's self-image and confidence level. The above task consisted of making a list of the client's strengths and how they could be used to help client view herself as useful and capable of making a contribution to society, and ultimately regain premorbid levels of functioning.

While continuing the above intervention, the next several sessions involved the therapist began assisting the client in making the connection between her dysfunctional beliefs and patterns of thoughts to her depression. G.G. was instructed to share specific events that had occurred during the preceding week or two, or about an event(s) surrounding a problem that had been targeted for change (crying spells, fearfulness, suicidal ideations). The therapist helped the clients focus on specific behavior, thoughts, self-statements, images, and emotions during these events. The therapist would point out the

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[4]Ibid., 216.

connections between certain behavior and how it related to or influenced G.G.'s depression. G.G. was eventually able to connect certain thoughts and behaviors to occurrence of a depressive episode.

In session, the client and therapist also worked on identifying thoughts and feelings that occurred before, during, and after certain events. This was practiced on a regular basis throughout following sessions and whenever new or different situations brought about dysfunctional cognitions. The client required much motivation and encouragement in order to successfully continue to identify these situations as causal factors of her depression.

Next R.K. helped the client replace self-defeating cognitions with functional self-statements. The therapist explained that changing ingrained patterns of thinking, feeling, and behaving would take some time, and that G.G. should not be discouraged with slow progress. Modeling was the main technique used to convey this phase of cognitive restructuring. The therapist gave examples of both functional and dysfunctional statements and had the client make some of her own. This process also continued throughout other sessions. Client was also asked to self-monitor by keeping a log of situations in which coping self-statements were used to replace self-defeating thoughts or misconceptions. The self-monitoring was not effective because G.G. was not entirely willing to keep a log - it required too much effort. Therefore, information on targeted symptoms was recorded and scored based upon direct recall and not on factual occurrence. Client also continued to take medication as directed.

Design

This study used the A-B-C design in assessing the effectiveness of the individual counseling sessions and the use of medication. The A-B-C design is an extension of the A-B single-case design. A-B-C is a successive intervention

which employs different intervention methods, each one after the other.[5] *A* refers to the non-intervention/observation period. Baseline data for this study was reconstructed using progress notes and therapist and client memory and assigned numerical value based upon client's self-report of frequency of crying spells, fearfulness, and suicidal ideations. *B* and *C* refer to an intervention period along with continued collection of data - individual counseling and pharmacotherapy respectively.

The basic assumption is that problems observed during baseline will likely continue in the same pattern if no changes are made in the "system of forces acting on these problems".[6] The intervention is a planned change seeking to modify the problematic events in a desired direction. The A-B-C design can indicate whether any changes occurred in the problematic behavior. This design provides a scientifically credible way to assess outcome that does not conflict with agency concerns about withholding, withdrawing, or delaying service delivery to clients.

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[5]Martin Bloom, Joel Fischer, and John G. Orme Evaluating Practice: Guidelines for the Accountable Professional 2ed. (Boston: Allyn and Bacon, 1995), 440.

[6]Ibid., 351-352.

CHAPTER FOUR

PRESENTATION OF RESULTS

Results

The results of this study are presented in Figure 1. The client's participation in individualized counseling was monitored for five months (September to January). Figure 1 presents general contentment levels during baseline and intervention phase. As shown contentment level ranged from 46 to 69, with a mean of 59 (S.D. = 19.2).

Limitations of the study

Limitations in this study include: (1) the fact that standardized questionnaires measure targets in terms of general concepts, but may not correspond to the unique realities of a particular client, (2) out of long-term habit, the client may not be aware of the occurrence of the target, and (3) the client may record and/or report what they think the clinician wants to know.

Discussion

There are a few factors, aside from counseling sessions, that may have influenced the client's scores. During the fourth month (December), the client's general contentment levels show increased "contentment" than at any other time during the five month period. It is of interest to note that the client's brother came to visit from New York that month. This demonstrates that although counseling generated somewhat of a change in symptoms, a person's surrounding environment also has a significant impact on mood change and decrease in depressive symptoms.

Client's scores may have been further influenced by her interpretation or understanding of certain questions. G.G. expressed that she truly did not know what "downhearted" (question 10) and "downtrodden" (question 17) meant. She

admitted to consistently answering with a score of 4 because it was in the middle and seemed "neutral". She also stated that question 14 was "difficult to answer" because suicide was an issue she was frightened of, yet struggled with often.

Finally, note should be made of additional factors that may have influenced intervention results: client's inconsistent attendance (many appointments were rescheduled due to non-compliance), and client's lack of motivation to keep track of self-defeating thoughts versus self-statements (making use of cognitive restructuring).

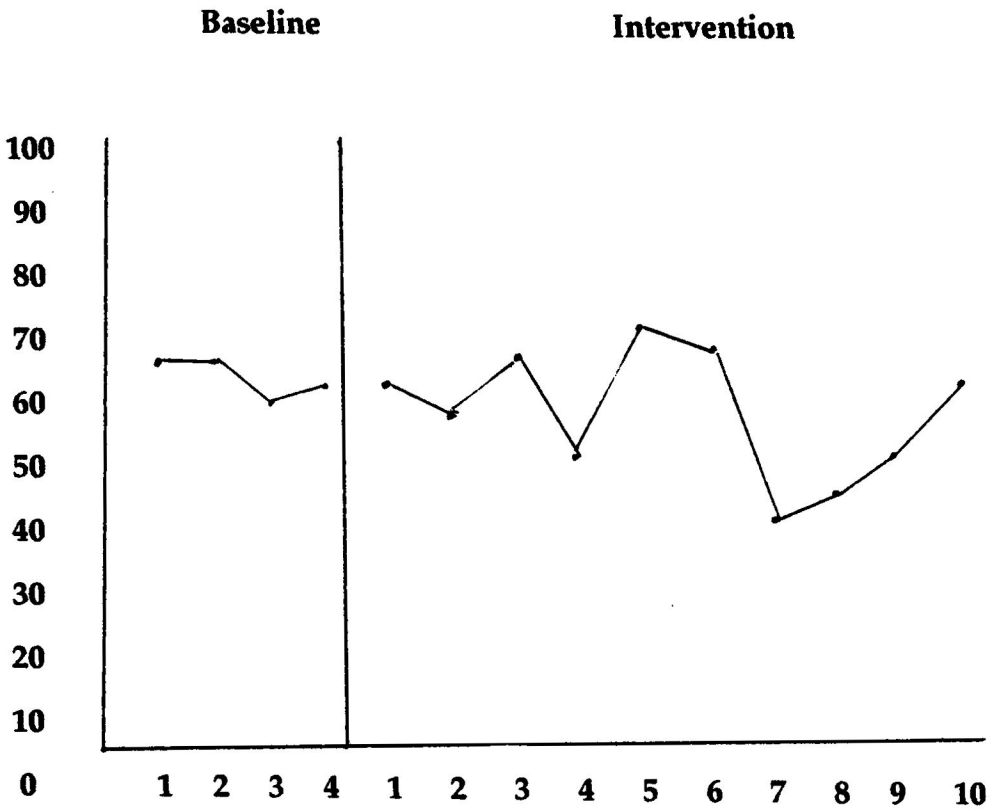

Figure 1: Scores on Index of General Contentment for Basline and Intervention Period for Client.

CHAPTER FIVE

SUMMARY AND CONCLUSION

Feeling sad is virtually a universal experience. In most instances, the sad mood lasts for only a short time. For some people, the sad mood can become intense and long lasting, coloring every aspect of existence. These people feel powerless to change, the future appears hopeless, and occasionally suicide seems to be the only answer. Depression of this type represents one of the most significant mental health problems facing our nations.[1]

The impact of this disorder is significant for both the individual experiencing depression and for society as well. The costs to society in decreased work productivity and the expense of treatments have been estimated to be as high as $11 billion per year. On a personal level, the toll of psychological pain and anguish experienced by depressed persons and their families is underscored by the significant number of studies related to depression. Some estimates suggest that as many as fifteen percent of severely depressed people eventually commit suicide.[2]

In the past twenty years, research on depression has progressed at a dramatic rate. The advent of cognitive-behavioral theories of depression has generated new perspectives for understanding depression as well as innovative and effective modalities for its treatment.[3] As research continues, the many different approaches of treatment bring hope and encouragement to clinicians and patients alike. The many known potential causes of depression, and even those yet known, are baffling and frustrating. However, ways to improve the

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[1]Arthur M. Nezu, Christine M. Nezu, and Michael G. Perri, Problem-Solving Therapy for Depression: Theory, Research, and Clinical Guidelines (New York: John Wiley and Sons, Inc., 1989), 3.

[2]Ibid.

[3]Ibid.

treatments for depression continue to be sought and the existing treatment approaches are continually being re-evaluated.[4]

Implication of findings to clinical social work practice

The purpose of clinical social work is to help individuals and families improve their social functioning and enhance the overall quality of their lives. This work starts with the premise that a "proper understanding of human behavior will include a balanced concern for the individual as a physical, spiritual, psychological and social entity."[5]

Social workers' impact on mental health problems is often limited by inappropriate intervention strategies due to misdiagnosis or incomplete assessment. Most treatment usually aims to relieve the symptoms, but fails to address the central problem. Social workers' impact on the progress of a client's treatment is further limited by those factors which influence the manifestation of a client's social functioning. Each influencing factor will play a significant role in the origin and perpetuation of all human behavior. Influencing factors include: internal factors - physical drives, physical health, social motivation, free will, central nervous system chemistry, and external factors - social history, social situation, cultural environment, and client's family environment.[6]

Social functioning is a circular process. Influencing factors mold the use of defense mechanisms. Defense mechanisms shape the problem solving patterns, and those patterns mold the influencing factors. The circle of social functioning can be a circle of growth or a circle of despair.[7] It is the task of the social worker to help the client interrupt, change, and redirect the vicious circle of personal and

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[4]Arthur Schwartz and Ruth M. Schwartz, Depression: Theories and Treatments (New York: Columbia University Press, 1993), 309.

[5]James E. Lantz, MSW, Ph.D., An Introduction to Clinical Social Work Practice (Illinois: Charles C. Thomas, 1987): 3.

[6]Ibid., 4.

[7]Ibid., 24.

social dysfunction. It is a task that requires careful and complete assessment, leading to an accurate diagnosis, and ending in a client specific intervention.

APPENDIX A

CONSENT TO RELEASE INFORMATION

I, _____, give Shannon A. Butler permission to use information in my chart at South Fulton Mental Health Center for research purposes. I am aware that information regarding my diagnosis and treatment will be used as part of her research thesis.

I have been informed that information gathered will be used only by Shannon A. Butler for research purposes towards the completion of academic requirements at Clark Atlanta University, in the School of Social Work, for the class titled SSW 598, Thesis Supervision. I understand that such information will not be used by or discussed with any other person(s) for any other reasons than those specified above.

I have been informed of my right to confidentiality and understand that my name, nor any other identifying information will be used in any way for this project.

I have also been informed that I may withdraw my consent at any given time.

_____ _____

Client Signature Researcher Signature

_____

Witness Signature
Practicum Instructor

APPENDIX B

Generalized Contentment Scale (GCS)

Name: _____ Today's Date: _____

This questionnaire is designed to measure the way you feel about your life and surroundings. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each on as follows:

1 = None of the time
2 = Very Rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = All of the time

1. ___ I feel powerless to do anything about my life.
2. ___ I feel blue.
3. ___ I think about ending my life.
4. ___ I have crying spells.
5. ___ It is easy for me to enjoy myself.
6. ___ I have a hard time getting started on things that I need to do.
7. ___ I get very depressed.
8. ___ I feel there is always someone I can depend on when things get tough.
9. ___ I feel that the future looks bright for me.
10. ___ I feel downhearted.
11. ___ I feel that I am needed.
12. ___ I feel that I am appreciated by others.
13. ___ I enjoy being active and busy.
14. ___ I feel that others would be better off without me.
15. ___ I enjoy being with other people.

16. ___ I feel that it is easy for me to make decisions.

17. ___ I feel downtrodden.

18. ___ I feel terribly lonely.

19. ___I get upset easily.

20. ___ I feel that nobody really cares about me.

21. ___ I have a full life.

22. ___ I feel that people really care about me.

23. ___ I have a great deal of fun.

24. ___ I feel great in the morning.

25. ___ I feel that my situation is hopeless.

BIBLIOGRAPHY

Abrmason, Lyn Y., Gerald I. Metalsky, and Lauren B. Alloy. "Hopelessness Depression: A Theory-Based Subtype of Depression." Psychological Review 96 (1989): 358-372.

Bloom, Martin, Joeal Fischer and John G. Orme. Evaluating Practice: Guidelines for the Accountable Professionl. Boston: Allyn and Bacon, 1995.

Beck, Aaron T. and David A. F. Haaga. "The Future of Cognitive Therapy." Psychotherapy 29 (1992): 34-38.

Conte, Hope R., PhD and T. Byram Karasu, MD. "A Review of Treatment Studies of Minor Depression: 1980-1991." American Journal of Psychotherapy. XLVI (1992): 58-73.

Elkin, Irene, Ph.D.; M. Tracie Shea, MD; John T. Watkins, Ph.D.; Stanley D. Imber, Ph.D.; Stuart M. Sotsky, MD; Joseph F. Collins, ScD; David R. Glass, Ph.D.; Paul A. Pilkonis, Ph.D.; William R. Leber, Ph.D.; John P. Docherty, MD; Susan J. Fiester, MD; and Morris B. Parloff, Ph.D.. "National Institute of Mental Health Treatment of Depression Collaborative Research Program: General Effectiveness of Treatments." Archives of General Psychiatry 46 (November 1989): 971-982.

Feighner, John P., MD. "A Review of Controlled Studies of Adinazolam Mesylate in Patients with Major Depressive Disorder." PsychoPharmacology Bulletin 22 (1986): 186-190.

Gotlib, Ian H., Peter M. Lewinsohn and John R. Seeley. "Symptoms Versus a Diagnosis of Depression: Differences in Psychosocial Functioning." Journal of Consulting and Clinical Psychology 63 (1995): 90-100.

Greist, John H., MD and Jefferson, James W. Depression and Its Treatment. Washington DC: American Psychiatric Press, 1992.

Hepworth, Dean H. and Larsen, JoAnn. Direct Social Work Practice: Theory and Skills. California: Brooks/Cole Publishing Comapny, 1993.

Jones, Enrico e. "Introduction to Special Section: Single-Case Research in Psychotherapy." Journal of Consulting and Clinical Psychology 61 (1993): 371-372.

Jones, Enrico E.; Jess Ghannam; Joel T. Nigg; and Jennifer F.P. Dyer. "A Paradigm for Single-Case Research: The Time Series Study of a Long-Term

Psychotherapy for Depression." Journal of Consulting and Clinical Psychology 61 (1993): 381-394.

Lantz, James E. An Introduction to Clinical Social Work Practice. Illinois: Charles C. Thomas, 1987.

Lewinsohn, Peter M., Harry M. Hoberman, and Gregory N. Clarke. "The Coping with Depression Course: Review and Future Directions." Canadian Journal of Behavioral Science 21 (1989): 470-493.

McLean, Peter D. and Sally Carr. "The Psychological Treatment of Unipolar Depression: Progress and Limitations." Canadian Journal of Behavioral Science 21 (1989): 452-469.

McLean, Peter and Steven Taylor. "Severity of Unipolar Depression and Choice of Treatment." Behavior Research Therapy 30 (1992): 443-451.

Munoz, Ricardo F.; Yu-Wen Ying; Eliseo J. Perez-Stable and Jeanne Miranda. The Prevention of Depression: Research and Practice. Baltimore: The John Hopkins University Press, 1993.

Murphy, George E., MD; Anne D. Simons, Ph.D.; Richard D. Wetzel, Ph.D. and Patrick J. Lustman, Ph.D.. "Cognitive Therapy and Pharmacotherapy." Archives of General Psychiatry 41 (January 1984): 33-40.

Nezlek, John B., Mark Imbrie and Glenn D. Shean. "Depression and Everyday Social Interaction." Journal of Personality and Social Psychology 67 (1994): 1101-1111.

Nezu, Arthur M., Christine M. Nezu, and Michael G. Perri. Problem-Solving Therapy for Depression: Theory, Research, and Clinical Guidelines. New York: John Wiley and Sons, Inc., 1989.

Rickels, Karl, MD; Hack R. Chung, MD; Irma B. Csanalosi, MD; Aaron M. Hurowitz, DO; Jerry London, DO; Kenneth Wiseman, DO; Myron Kaplan, DO; and Jay D. Amsterdam, MD. "Alprazolam, Diazepam, Imipramine, and Placebo in Outpatients with Major Depression." Archives of General Psychiatry 44 (October 1987): 862-866.

Robinson, Leslie A., Jeffrey S. Berman, and Robert A. Neimeyer. "Psychotherapy for the Treatment of Depression: A Comprehensive Review of Controlled Outcome Research." Psychological Bulletin 108 (1990): 30-49.

Sartorius, Norman. "Cross-Cultural Research on Depression." Psychopathology 19 (1986): 6-10.

Schwartz, Ruth M. and Schwartz, Arthur. Depression: Theories and Treatments. New York: Columbia University Press, 1993.

Segal, Zindel V., Brian F. Shaw, and Doreen D. Vella. "Life Stress and Depression: A Test of the Congruency Hypothesis for Life Event Content and Depressive Subtype." Canadian Journal of Behavioral Science 21 (1989): 389-400.

Simons, Anne D., Ph.D., Sol L. Garfield, Ph.D., and George E. Murphy, Md. "The Process of Change in Cognitive Therapy and Pharmacotherapy for Depression." Archives of General Psychiatry 41 (January 1984): 45-51.

Stewart, Jonathan W., MD, Frederic M. Quitkin, MD, and Donald F. Klein, MD. "The Pharmacotherapy of Minor Depression." American Journal of Psychotherapy XLVI (January 1992): 23-35.

Swoboda, Joseph S., E. Thomas Dowd and Steven L. Wise. "Reframing and Restraining Directives in the Treatment of Clinical Depression." Journal of Counseling Psychology 37 (1990): 254-260.

Taylor, Steven and Peter McLean. "Outcome Profiles in the Treatment of Unipolar Depression." Behavior Research Therapy 31 (1993): 325-330.

Watkins, John T.; William R. Leber; Stanley D. Imber; Joseph F. Collins; Irene Elkin; Paul A. Pilkonis; Stuart M. Sotsky; M. Tracie Shea; and David R. Glass. "Temporal Course of Change of Depression." Journal of Consulting and Clinical Psychology 61 (1993): 858-864.

Wierzbicki, Michael and Thomas S. Bartlett. "The Efficacy of Group and Individual Cognitive Therapy for Mild Depression." Cognitive Therapy and Research 11 (1987): 337-342.

Zettle, Robert D., Jane L. Haflich, and Roy A. Reynolds. "Responsivity to Cognitive Therapy as a Function of Treatment Format and Client Personality Dimensions." Journal of Clinical Psychology 48 (1992): 787-796.